STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445107	A. BUILDING _____ B. WING _____	C 04/12/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NHC HEALTHCARE, FT SANDERS	2120 HIGHLAND AVE KNOXVILLE, TN 37916

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Investigation of C/O #27603 and C/O #27651 was conducted on April 11, 2011, at NHC Healthcare Ft Sanders. No deficiencies were cited for C/O #27651.	F 000		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure one resident (#4) was free of a significant medication error of five residents reviewed. The findings included: Resident #4 was admitted to the facility on December 23, 2010, with diagnoses including Cerebrovascular Accident (Stroke), Aphasia, Dysphagia, Pneumonia, Depression, Multi-infarct Dementia, Anxiety, Renal Insufficiency, Psychosis, Agitation, Adult Failure to Thrive and Right Pleural Effusion. Medical record review of the Minimum Data Set dated January 12, 2011, revealed the resident had moderate impairment of decision-making skills and required extensive assistance with all activities of daily living. Medical record review of a nurse's note dated February 10, 2011, at 7:45 a.m., revealed, "...appeared lethargic...Talking to staff but appeared drowsy..." Medical record review of a nurse's note dated	F 333	F 333 1. Resident #4 returned to center in stable condition, at baseline. 2. Residents residing on hall assessed. No others found to be affected. All MARS assessed for proper labeling and resident identification. Resident armbands assessed for proper identification. 3. Nurse involved in incident verbally counseled regarding proper administration of medication protocol and reassigned to preceptor trainer for further education and monitoring. All licensed nursing personnel to be in-serviced on administration of medication protocol. 4. Floor supervising RN and Risk Management Nurse, in coordination with the consultant pharmacist will monitor for following of administering of medication protocol.	02/10/11 02/11/11 02/11/11 02/11/11 04/20/11 04/20/11 and On-Going

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Douglas S. Ford — TITLE: N.H.A. — (X6) DATE: 4/19/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 333	Continued From page 1 February 10, 2011, at 9:00 a.m., revealed, "(Blood Pressure) 95/63...felt diaphoretic...from wheelchair to bed. Elevated feet. Pt's (Patient)skin returned to normal. Felt warm & (and) dry..." Medical record review of a nurse's note dated February 10, 2011, at 11:10 a.m., revealed, "...Respirations 5-BP (Blood Pressure) 112/64...Going to (hospital)...staring up at ceiling with eyes open. Still responding to name." Review of an emergency room report dated February 10, 2011, revealed Narcan (medication to reverse the effects of narcotic overdose) was administered to reverse the effects of the narcotic which had been administered to resident #4. Medical record review of a nurse's note dated February 10, 2011, at 6:00 p.m., revealed, "Returns to facility...Alert & responsive...Resp. (respirations) even and unlabored." Interview on April 11, 2011, at 11:25 a.m., with the Director of Nursing confirmed resident #4 was given resident #5's 6:00 a.m., Methadone (narcotic analgesic) on February 10, 2011. Medical record review of the physician's orders for resident #5, dated February 1-28, 2011, revealed, "...Methadone HCL (Hydrochloride) 10 mg (milligram) tablet...Give 4 tablets (40 mg) by mouth three times daily at 6AM, 2PM, and 10PM..." Telephone interview on April 11, 2011, at 3:30 p.m., with the Registered Nurse (RN) on duty on day shift on February 10, 2011, confirmed resident #5 reported "...did not get Methadone	F 333	See Page 1 of 3	

APR 20 2011

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F 333	Continued From page 2 (6:00 a.m.)...is well aware and can tell us this." Continued interview with the RN confirmed resident #4 was "making comments and laughing-not like (resident)", and confirmed the resident's respirations "begun to get lower and lower. We thought we better send...out...called hospital and they said they had gotten...respirations back up and were sending...back..." Telephone interview on April 11, 2011, at 3:45 p.m., with the Licensed Practical Nurse (LPN) who was assigned to the resident on night shift on February 9-10, 2011, confirmed the LPN went into the room to administer the 6:00 a.m., Methadone to resident #5 when a Certified Nursing Assistant requested assistance from the LPN. Continued interview confirmed the LPN "got confused" and administered Methadone 40 mg, belonging to resident #5, to resident #4. The LPN stated, "I got my wires crossed and gave it to the resident in B bed instead of A bed." C/O #27603	F 333	See Page 1 of 3	